MINISTRY OF HEALTH SERVICES/HEALTH PLANNING

Development of a Mental Health and Addictions Information Plan for Mental Health Literacy 2003-2005

Health literacy is the ability to gain access to, understand, and use information to promote and maintain good health. Mental health literacy refers to knowledge and beliefs about mental disorders, which assist in the recognition, management or prevention of mental health and substance use problems, and mental and substance use disorders. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, self-management, and of professional help available; and attitudes that promote recognition and appropriate help seeking.

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Mental Health and Addictions
Ministry of Health Services

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A. Introduction

The Province of British Columbia envisions an evidence-based, health promotion, prevention and recovery-oriented mental health and addictions system of care that supports resiliency, self-care and access to necessary mental health and addictions care. The Ministry of Health Services/Health Planning is committed to mental health and addictions sector reform in British Columbia.

The Ministry of Health Services Service Plan has identified 3 goals as follows:

Goal 1: High Quality Patient-Centered Care
Patients receive appropriate effective, quality care at the right time in the right setting and health services are planned, managed and delivered around the needs of the patient.

Goal 2: Improved Health and Wellness for British Columbians
Support British Columbians in their pursuit of better health through protection, promotion and prevention activities.

Goal 3: A Sustainable, Affordable Public Health System
A planned, efficient, affordable and accountable public health system, with governors, providers and patients taking responsibility for the provision and use of these services.

To support achieving the Ministry's goals for system renewal, the goals for mental health and addictions sector reform in British Columbia over the next five years are to:

- Apply evidence-based mental health and addictions promotion and illness prevention initiatives;
- Develop a continuum of accessible, evidence-based, recovery-oriented acute and community mental health and addictions services in each health authority;
- Implement a system of accessible, evidence-based tertiary mental health and addictions services across the province; and
- Ensure evidence-based quality information is accessible to people whom experience mental illness or substance use disorders, their families, service providers and communities.

The long term outcomes for mental health and addictions sector reform in British Columbia are:

- Improved mental health in the population;
- Prevention of mental health problems, mental disorders and substance disorders;
- Reduction in substance misuse in the population;
- Reduced impact and disability from mental health problems, mental disorders and substance use disorders on individuals, families, and the community; and
- Reduced need for health services.

The long term outcomes for mental and addictions sector reform will be supported in large part through improving population health literacy. Health literacy is the ability to gain access to, understand, and use information to promote and maintain good health. Mental health literacy refers to knowledge and beliefs about mental disorders, which

assist in the recognition, management or prevention of mental health and substance use problems, and mental and substance use disorders. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking.

The lifetime risk of developing a mental disorder including substance use disorders is so high (nearly 50%)[1] that almost the whole population will at some time have direct experience of such a disorder, either in themselves or in someone close. A high public level of mental health literacy would make early recognition of and appropriate intervention in these disorders more likely.[2]

It is useful to begin with a clear understanding of what is meant by terms such as mental health, mental health problem, mental disorder and substance use disorder:

- Mental health is the capacity of the individuals and groups to interact with one another and the environment in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality. [3] Mental well-being is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. [4]

- A mental health problem is a disruption in the interactions between the individual, the group and the environment. Such a disruption may result from factors within the individual, including physical illness, mental disorder, substance use disorder or inadequate coping skills. It may also spring from external causes, such as the existence of harsh environmental conditions, unjust social structures, or tensions within the family or community; [5]

- A substance use problem is associated with physical, psychological, economic, or social problems, which together constitute a risk to health, security, or well-being of individuals, families, and communities. Whether or not any particular use is problematic depends on the individual, the behaviour, and the context.

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1 Jorm A, Korten A, Jacomb P, et al. (1997). "Mental health literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment". Medical Journal of Australia. pp 166: 182. http://www.mja.com.au/public/issues/feb17/jorm/jorm.html

2 Jorm A, Korten A, Jacomb P, et al. (1997). "Mental health literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment". Medical Journal of Australia. pp 166: 182. http://www.mja.com.au/public/issues/feb17/jorm/jorm.html

3 Pape B, & Galipeault, J. (unpublished). *Mental Health Promotion for People with Mental Illness (a discussion paper)*. pp 6-7

4 US Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General*. Rockville, Maryland: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. http://www.surgeongeneral.gov/library/mentalhealth/home.html

5 Pape B, & Galipeault, J. (unpublished). *Mental Health Promotion for People with Mental Illness (a discussion paper)*. pp 6-7

- A mental disorder is a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities; [6] and,

- A substance use disorder is a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. The essential feature of substance use disorder is a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking behaviour. [7]

Increasing mental health literacy is one component in improving overall mental health. Improving overall mental health requires a broader mental health promotion approach which will be explicitly encompassed within the Ministry of Health Planning, public health framework. Mental health promotion is defined as "the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health." Mental health promotion:

- "seeks to enhance mental health rather than prevent mental disorders, and it serves the population at large as well as subgroups,"
- focuses on strength rather than incapacity, on "nurturing what is best within ourselves" rather than "fixing what is broken," and
- is equally as important for those persons without a history of disorders, for people at risk of developing disorders, and for persons with a mental disorder or a substance use disorder.

The information plan will increase mental health literacy in the general population and support increased mental health and mental illness management skills for people with mental disorders and substance use disorders. The information provided will be evidence-based and consistent with the intent to improve the mental health of British Columbians and to minimize the need for health services.

A mental health and addictions information plan is being developed not only to improve mental health literacy in the general population but to ensure information is accessible on an ongoing basis to people with mental disorders and substance use disorders, their families, and those people providing direct and indirect care and support. The plan will therefore provide for access to necessary evidence-based information targeted to specific individual and professional needs. To support meeting this goal, evidence-based information will be provided in a timely, respectful way, with sensitivity to age, gender, ethno-cultural background, lifestyle, and level of knowledge. The vehicles for information sharing will be varied to address levels of literacy, communication barriers (including language and sensory barriers), geographic and technological barriers to access to information.

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[6] Pape B, & Galipeault, J. (unpublished). *Mental Health Promotion for People with Mental Illness (a discussion paper)*, pp 6-7

[7] American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders (4th Ed.), DSM-IV TM. Washington, DC. p 176

The services and supports required by those who experience mental disorders and substance use disorders are provided across ministries and multiple agencies. Therefore, an effective information plan requires establishing and sustaining broader partnerships across ministries, health authorities, educational institutions, non-profit organizations as well as partnerships with the private sector including media and business representatives. Hence as the plan evolves, a greater emphasis will be placed on creating permanent collaborative partnerships with all sectors.

In summary, improving mental health literacy will:

- Enhance the ability of people with mental disorders and substance use disorders, and their families to make informed choices and decisions regarding the types of services and supports they require to assist them to live productive quality lives.
- Support individuals and families to work more effectively with their health care providers.
- Provide the opportunity for British Columbians to manage many of their issues arising from their mental disorders and substance use disorders through timely, up-to-date information and appropriate tools. In addition, increased awareness and early intervention can be supported through quality, timely information, thereby reducing the extent of disability and burden of disease.
- Be a prime opportunity to reduce the discrimination experienced by people with experience of mental disorders and substance use disorders and to improve the quality of services they receive by:
    i. Informing people about mental health, mental disorders and substance use disorders;
    ii. Promoting greater understanding and support for people with mental disorders and substance use disorders, and their families; and,
    iii. Providing people with experience of mental disorders and substance use disorders information to better exercise their rights as citizens.

B. Goal of Mental Health and Addictions Information Plan

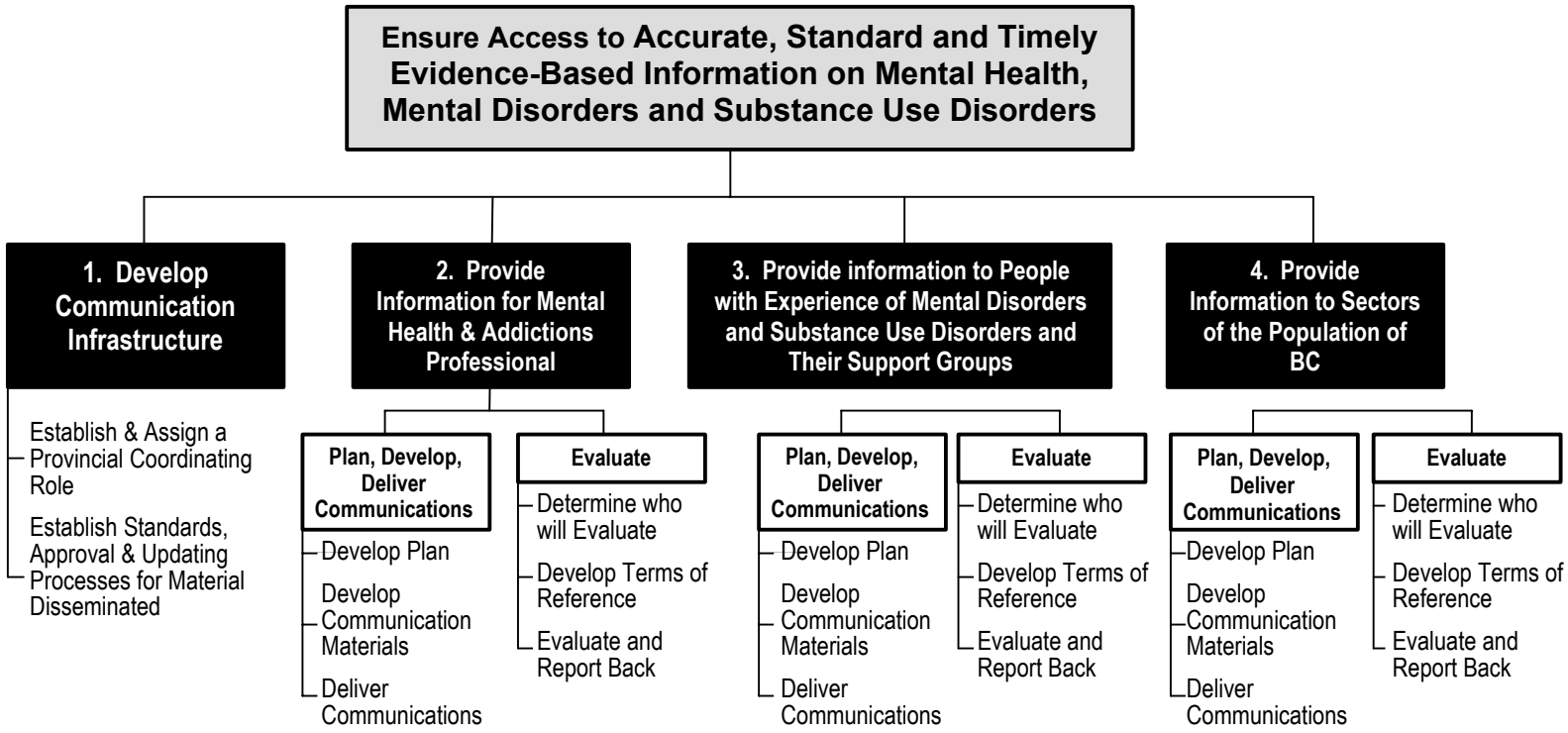
The goal of the Mental Health and Addictions Information Plan is to develop a permanent communications infrastructure over the next three years to improve mental health literacy by obtaining the following three objectives (see Figure 1):

1. People with experience of mental disorders and substance use disorders, and families have access to accurate, standard and timely information on mental health, mental disorders, and substance use disorders including information on evidence-based services, supports, and self-management.

2. Professionals in a variety of service sectors have access to accurate, standard and timely information on mental health, mental disorders and substance use disorders including information on evidence-based services and supports including self-management.

3. The general public has access to accurate, standard and timely information on mental health, mental disorders and substance use disorders including information on evidence-based services, supports and self-management.

Figure 1: Mental Health and Addictions Information Project



C. The Guiding Principles for Plan Development

1. Acknowledge and build on the work already done by individuals and groups in providing mental health, mental disorders and substance use disorders information.

2. Ensure the mental health and addictions information plan activities support reducing discrimination and stigma of people with experience of mental disorders and substance use disorders.

3. Ensure people with experience of mental disorders and substance use disorders, and their families are included in the development and implementation of the information plan.

4. Ensure participation of Aboriginal peoples and ethno-cultural groups in the development and implementation of an information plan to meet their unique needs.

5. Ensure best evidence in effective communication practices are used in the development of all the information related to the plan.

6. Ensure that provincial, local and regional information activities are included and linked to the mental health and addictions information plan to support effective and coordinated activities.

7. Ensure the mental health and addictions information plan is evaluated, sustainable over time, and leaves a permanent legacy.

D. Critical Considerations for Developing an Effective Mental Health and Addictions Information Plan

Information is necessary for change but not sufficient on its own to ensure change. To develop and implement an effective plan, a review of the literature revealed the following key areas for consideration in ensuring the plan will make a difference must:

1. Be part of a comprehensive health promotion approach
2. Ensure active involvement of people with experience of mental disorders and substance use disorders
3. Involve the total health sector
4. Influence the media to positively influence social attitudes
5. Support community action/mobilization
6. Include a rights-based approach
7. Ensure provincial coordination
8. Consider burden of disease and why it persists
9. Support self-management approaches including improving personal health practices, coping skills, and social support networks

1. Be Part of a Comprehensive Health Promotion Approach

The basis of successful health promotion is a comprehensive approach: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and, re-orienting health services. Prevention of mental disorders and substance use disorders, mental health promotion, and community education requires community-based programming that addresses the full continuum of factors based on accurate, current evidence-based information.

2. Ensure Active Involvement of People with Experience of Mental Disorders and Substance Use Disorders

Studies of attitudes towards people with experience of mental disorders and substance use disorders consistently find that people who know someone with a mental disorder or substance use disorder are generally less likely to embrace negative stereotypes and are less likely to perceive people with experience of mental disorders and substance use disorders as dangerous. The findings of these studies lead to the position that negative attitudes can be reduced by promoting direct contact between members of the public and people with experience of mental disorders and substance use disorders. Donaldson[8] found that structured experiences or presentations involving people with mental disorders were more effective than informal contacts, mainly because structured situations give the person with a mental disorder equal status in the relationship. Therefore, the contribution of people with experience of mental disorders and substance

[8] Donaldson J. (1980). Changing attitudes to handicapped persons: a review and analysis of research. *Exceptional Children 46(7).* pp 504-514.

use disorders is extremely important to the success of a mental health and addictions information plan.

This approach is supported by Barwick's[9] review of the literature on changing public attitudes towards people with experience of mental disorders, which identified the following key influences in order of effectiveness:

- Direct contact with people with experience of mental disorders and substance use disorders;
- Indirect exposure via the media to people with experience of mental disorders and substance use disorders; and,
- Information and persuasion.

3. Involve the Total Health Sector

Surveys of mental health service users[10,11] find that most people's experience of stigma and discrimination occurs in health service. This results their receiving a lower quality of physical and mental health care in the total health care system. In addition, Collings and Ellis[12] note that even mental health professionals may devalue their client group or particular sub-groups, and general health care providers may also not take clients' concerns seriously with consequent neglect of physical symptoms and symptoms of mental disorders. It is therefore essential that the information plan includes providing evidence-based information within the health services sector as a whole, including the mental health and addictions service sector.

4. Influence the Media to Positively Influence Social Attitudes

There is evidence that the media has a major role in creating and perpetuating negative stereotypes of people with experience of mental illness.[13,14,15,16,17] Most efforts to change public attitudes use the mass media. Studies of other health promotion campaigns affirm its benefit in creating a climate of opinion that is supportive of healthy public policies.[18] However, it is also generally accepted that the media is better at

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9 Barwick H. (1995). Positively Influencing Public Attitudes to People with a Psychiatric Disability. Wellington: Central Regional Health Authority.

10 Wahl O. (1997). Stigma and mass media. In Bernheim K. (Ed). *Cases and readings in abnormal behaviour.* Baltimore, MD: Lanahan Publishers. pp.357-361.

11 MIND's 'Respect' campaign (1996) and 'Creating Accepting Communities' campaign (1999) www.mind.org.uk

12 Collings S and Ellis P. (1997). Biological, social and economic risk factors. In,Ellis P and Collings S. (Eds). *Mental Health in New Zealand from a Public Health Perspective*. Wellington, New Zealand: Ministry of Health.

13 Wilson C., Nairn R. Coverdale J et al. (1999a). Mental illness depictions in prime-time drama: identifying the discursive resources. *Australian and New Zealand Journal of Psychiatry 33.* pp. 232-239.

14 Wilson C, Nairn R, Coverdale J et al. (1999b). Constructing mental illness as dangerous: a pilot study. *Australian and New Zealand Journal of Psychiatry 33.* pp 240-247.

15 Allen R and Nairn R. (1997). Media depictions of mental illness: An analysis of the use of dangerousness. Australian and New Zealand Journal of Psychiatry 31. pp 375-381.

16 Wahl O. (1995). *Media Madness: public images of mental illness*. New Brunswick, New Jersey: Rutgers.

17 Philo G, Secker J, Platt S, et al. (1994). Impact of the mass media on public images of mental illness: media content and audience brief. *Health Education Journal 53*: pp 271-281.

18 Wyllie A. (1997). Evaluation of a New Zealand campaign towards reduction of intoxication on licensed premises. *Health Promotion International 12(3).* pp 197-207.

confirming attitudes and slow at changing them. Brown's[19] review of mass media campaigns concludes that mass media campaigns cannot convey complex information; or teach complex motor skills; or shift attitude/change people who are resistant; or provide the support necessary for motivation of individuals who wish to change their behaviour in adverse physical and social circumstances. The information plan must therefore address media leaders' perceptions as well as a plan for the use of media as a medium for change.

5. Support Community Action/Mobilization

Evaluations of information campaigns have demonstrated that effective plans set realistic outcome criteria and are backed up with community-based education and training.[20,21,22,23] While media can be most effective at raising awareness and changing the climate of opinion, changing behaviour requires more direct action. The plan must therefore include educational and information activities at the grassroots level to provide opportunities to confront misinformation, fear, stigma and discrimination more directly, to adapt messages to the different cultures that make up society in British Columbia and to address obstacles in the real situations in which they occur.

Community mobilization is a common process that draws together a number of groups or organizations into collaborative actions around a specific topic, issue, or event. The purpose of community mobilization is to increase participation of communities in mental health and addiction issues by mobilizing community groups and organizations to select the issue and enhance and utilize the capacities inherent in the community. The information plan must support community-based action in order to be effective.

6. Include a Rights-Based Approach

Eagly and Chaiken[24] identify other influences on behaviour apart from attitudes, such as habits, self-identity and norms. Studies of other efforts to change behaviour, such as the International Labour Organization's[25] studies of racial discrimination in the workplace, have found that a rights-based approach, involving enforcement of sanctions against discriminatory behaviour, and redress for victims, is necessary. But legal provisions alone are unlikely to resolve the issue entirely, and it is also important to complement law with education and training. Training helps people to understand why legal provisions are in force. Once behavioural habits have changed, attitudes follow, and non-discriminatory behaviour becomes the new norm. The information plan will

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19 Brown P. (1996). A review of mass media campaigns as a form of health education. *Journal of International Health Education 34(2).* pp 51-56.

20 Donaldson J. (1980). Changing attitudes to handicapped persons: a review and analysis of research. *Exceptional Children 46(7).* pp 504-514.

21 Barker C, Pistrang N., Shapiro D, Davies S, and Shaw I. (1993). You in Mind: A preventive mental health television series. *British Journal of Clinical Psychology, 32(3).* pp 281-293.

22 Reid D, McNeill A, and Glynn T. (1995). Reducing the prevalence of smoking in youth in Western countries: an international review. *Tobacco Control 4*: pp 266-277.

23 Wolff G, Pathare S, Craig T, et al. (1996). Public Education for Community Care. *British Journal of Psychiatry, 168. pp* 441-447.

24 Eagly A and Chaiken S. (1993). *The Psychology of Attitudes*. Fort Worth: Harcourt Brace Jovanovich College Publishers.

25 International Labour Organization (ILO). (1999). *International Labour Review Publications. Vol. 138, No. 2.*

need to include as a basis an understanding of the rights of people with mental disorders and substance use disorders and their families under B.C. legislation.

7. Ensure Provincial Coordination

British Columbia has a number of provincial and regional mental health and addictions agencies, ministries and health authorities involved in various mental health and addictions information and education activities. It is apparent that there is a lack of a coordinated approach to public information and education with a wide range of providers with varying levels of expertise and resources pursuing very different approaches, values and principles. In addition, there is duplication, variation in quality and a general lack of communication regarding a collective vision amongst the various stakeholders involved. While the process of developing a shared vision and consistent and complementary provincial and regional approaches to improving mental health literacy can be complex, it can result in standard, quality, cost-effective information products which reflect the creativity, cultural diversity, and special interests of current providers.

The Ministry of Children and Family Development has released a Child and Youth Mental Health Plan. A significant component of the plan is the implementation of a public information strategy. The opportunity exists to link and ensure a comprehensive mental health literacy information plan for the province. This will ensure coordinated, quality information across the spectrum of ages and programs for child, youth and adults.

Clear provincial coordination and effective partnerships are required to ensure limited resources are effectively used to meet the goals of providing quality, timely evidence-based information across the province and multiple sectors.

8. Consider Burden of Disease and Why It Persists

As resources are limited, priorities need to be set. The question of where to begin is answered in part by looking at the evidence available on which disorders have the greatest impact on health of the population. The World Health Organization has determined that mental illness is one of the largest contributors to disability worldwide. When the combined loss of life and disability is estimated using Disability Adjusted Life Years (DALYs), more than 10% of the total burden of human disease is attributed to mental disorders and substance use disorders.[26] Of the ten leading causes of disability worldwide, five are mental disorders and substance use disorders: Major Depression; Schizophrenia; Bipolar Disorder; Alcohol Use Disorder; and Obsessive Compulsive Disorder. Projections of future trends predict that the burden of illness caused by mental disorders and substance use disorders will continue to increase due to changes in the age of the population and to social and economic factors. It has been estimated that within the next two decades, depressive illnesses will become the second leading cause

[26] Murray C, & Lopez A. (1996). Chapter 7: Alternative visions of the future: Projecting mortality and disability, 1990 – 2020. *The Global Burden of Disease.* Cambridge: Harvard University Press. p 374

of disease burden worldwide and the leading cause in developed countries such as Canada.[27]

One reason why the burden of illness associated with mental disorders is so great is the high prevalence rate of mental health problems and mental disorders amongst the general population. Large-scale epidemiological studies undertaken in North America, Europe and Australia have found that approximately 20% of most populations meet diagnostic criteria for at least one mental disorder during the course of one year. If one sums the prevalence rates of the individual disorders studied, the total far exceeds 20% because of the high levels of co-morbidity amongst the various mental disorders.[28] Thus, it is estimated that approximately 656,000 British Columbians experienced mental disorder or substance use disorder in 1999/2000.[29] The cost of treatment, care and supportive services provided to these clients through community and institutional programs, including physician services, accounted for $755 million or 8% of the 1999/2000 health care budgets.[30]

Anxiety disorders, mood disorders, and substance use disorders are consistently found to be the most prevalent of mental disorders at 17%, 11%, and 11% twelve-month prevalence respectively.[31] Many of the findings of the Australian National Survey of Mental Health and Well Being[32], the most recent and comprehensive epidemiological study of mental disorders, are likely to be applicable to the Canadian population. Graphs 1 and 2[33] summarize prevalence data from the Australian survey for females and males and show the gender differences that are characteristic. Mood disorders and anxiety disorders are more common among females whereas substance use disorders are more prevalent in males. In recent years, approximately 300,000 British Columbians have seen a physician for problems related to depression or anxiety each year. More than 200,000 of those seen each year were female.[34]

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27 World Health Organization. (2001). *The World Health Report 2001: Mental health: New understanding, new hope*. Geneva, Switzerland. http://www.who.int/whr/2001/main/en/pdf/whr2001.en.pdf p 30

28 Goldner E, Snider B, & Mozel M. (2002). *Defining the Challenge: Epidemiology of Mental Disorders in British Columbia, Estimating the Prevalence of Mental Disorders in Adults.* Vancouver, British Columbia: Mental Health Evaluation & Community Consultation Unit (Mheccu), Department of Psychiatry, University of British Columbia. http://www.mheccu.ubc.ca/publications/epid1.pdf p 38

29 Ministry of Health Services, Mental Health and Addictions. (March 2002). *Assessing the Performance of the British Columbia Mental Health System: A Provincial Report 1999/2000 (draft)*. Province of British Columbia. p i

30 Ministry of Health Services, Mental Health and Addictions. (March 2002).

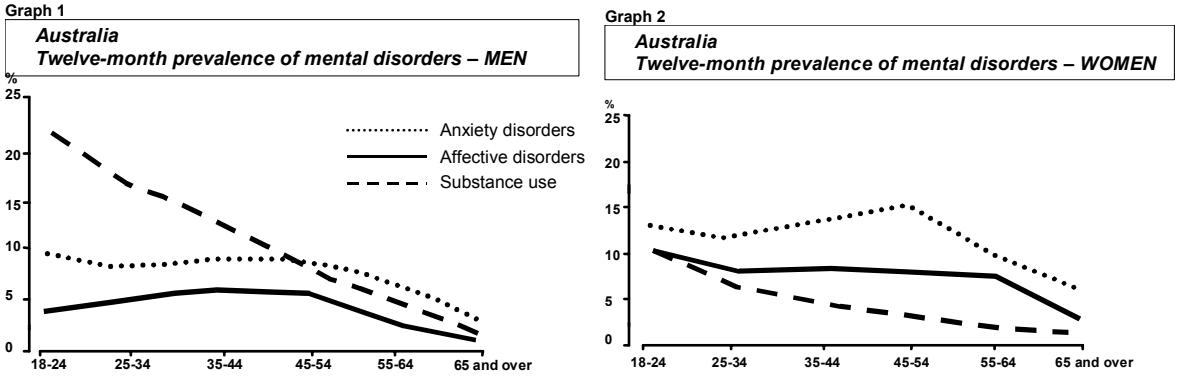
31 Australian Bureau of Statistics. (December 1998). *Mental Health and Well-being, Profile of Adults, Australia.* Australia: AusStats.http://www.abs.gov.au/ausstats/abs@.nsf/b06660592430724fca2568b5007b8619/3f8a5dfcbecad9c0ca2568a900139380!OpenDocument Types of disorders, ¶ 1

32 Australian Bureau of Statistics. (December 1998).

33 Australian Bureau of Statistics. (December 1998). Types of disorders, ¶ 6

34 Ministry of Health Services. (October 2002). *British Columbia's Provincial Depression Strategy – Phase 1 Report*. Province of British Columbia. http://www.healthservices.gov.bc.ca/mhd/pdf/depressionstrategy.pdf p 7

Summary of Findings of the Australian National Survey of Mental Health and Well-Being
(Twelve months prevalence rates for anxiety disorders, mood disorders or substance use disorders)



The high prevalence rate is an important reason to support preventive measures to decrease the incidence of mental health problems, mental disorders and substance use disorders. Additionally, health promotion activities that can increase the population's capacity to cope with stressors and maintain good mental health may also prove to be important.

Although some mental disorders and substance use disorders may have lower prevalence rates, they can cause profound disability in many of the people who are affected due to recurrent or long-lasting symptoms. Disorders such as schizophrenia, bipolar disorder, anorexia nervosa, personality disorder(s), and various compulsive and substance use disorders are often associated with great suffering and loss of quality of life for those affected and their families.

Co-morbidity amongst mental disorders is common. Almost 80% of persons who suffer from one mental disorder at some point in their life will meet criteria for more than one mental disorder.[35] Epidemiological studies have found that half of the people affected by mental disorders meet criteria for two or more co-occurring diagnoses.[36] The presence of co-occurring mental disorders increases the complexity of a person's treatment and the potential severity of their mental condition. Furthermore, the presence of a substance use disorder and a mental disorder concurrently is associated with poorer treatment outcomes. Overall, there is evidence that the incidence of concurrent disorders (mental disorder and substance use disorder) is increasing, compounded by the general lack of accessible evidence-based treatment programs for concurrent disorders.[37,38,39]

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35 Daniel C. (Fall 2000). When it rains, it pours: The co-occurrence of depression and other mental illnesses. *British Columbia's Mental Health Journal: Visions 11,* pp 6-7. Canadian Mental Health Association. http://www.cmha-bc.org/content/resources/visions/issues/11.pdf

36 US Department of Health and Human Services. (1999). Chapter 2: The Fundamentals of Mental Health and Mental Illness – Overview of Mental Illness, Epidemiology of Mental Illness, ¶ 2

37 Drake R, Mercer-McFadden C, Meuser K, et al. (January 1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin 24 (4), pp 589-608.* Bethesda, Maryland: National Institutes of Mental Health.

38 Hodgins S. (May 1996). The major mental disorders: New evidence requires new policy and practice. *Canadian Psychology 37 (2).* Ottawa, Ontario: Canadian Psychological Association. p 97

The impact of chronic or severe mental disorder may be further exacerbated because of increasing co-morbidity with other major problems such as violence, poor health practices, sexually transmitted diseases, and, HIV/AIDs. A series of studies have reported strong associations between mental disorders, unemployment, suicide attempts, spousal abuse, child abuse, alcoholism, crime (incarceration) and gambling.[40,41,42,43]

In summary, the burden of disease from mental disorders and substance use disorders is extensive. Although effective health promotion, prevention and treatment interventions exist in varying degrees and have grown for a number of mental disorders and substance use disorders, a wide spectrum of research activities holds promise in identifying new methods to reduce the burden of disease. Effective health promotion and prevention services in communities, schools and workplaces have been studied and promoted, yet the incidence and prevalence of mental disorders and substance use disorders continues to increase. Effective treatments exist for a number of common mental health problems, mental disorders and substance use disorders, including various forms of mood and anxiety disorders, and substance use disorders, yet a large proportion of people who could benefit from these treatments do not receive them. Surveys indicate that 40% of individuals with mental disorders have not sought treatment for the episode of illness and only 45% were offered treatment that could have been beneficial.[44]

The burden of illness often persists because:

- mental disorders and substance use disorders are not identified (either by those affected or by the healthcare system);
- treatment is not sought by those affected;
- treatment is not provided early;
- treatment is sought but the specific treatment chosen is ineffective.

Thus, for both the recipients and providers of mental health and addictions services, and the general public, there are significant gaps in knowledge and practice in the management of mental disorders and substance use disorders. In conclusion, the evidence indicates there is a need for an information plan to:

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[39] RachBeisel J, Scott J, & Dixon L. (November 1999). Co-occurring severe mental illness and substance use disorders: A review of recent research. *Psychiatric Services 50 (11),* pp 1427-34. Washington, DC: American Psychiatric Association. http://psychservices.psychiatryonline.org/cgi/content/full/50/11/1427 Treatment delivery model ¶ 1

[40] Bland R. (October 1998). Psychiatry and the burden of mental illness. *Canadian Journal of Psychiatry 43 (8),* pp 801-10. Ottawa, Ontario: Canadian Psychiatric Association. http://www.cpa-apc.org/Publications/Archives/CJP/1998/Oct/bland.htm Native health/Violence section

[41] Morrow M. (November 2001). *Violence and Trauma in the Lives of Women with Serious Mental Health Problems: Current Practices in Service Provision in British Columbia* . Vancouver, British Columbia: British Columbia Centre of Excellence for Women's Health. p 5

[42] Morrow M. (June 2002). *Women and Mental Health Across the Life Span: Creating a National Cross-Disciplinary Research Agenda and Strategy: Symposium.* Vancouver, British Columbia: British Columbia Centre of Excellence for Women's Health. p 9

[43] Morrow M, & Chappell M. (1999). *Hearing Women's Voices: Mental Health Care for Women.* Vancouver, British Columbia: British Columbia Centre of Excellence for Women's Health, British Columbia Ministry of Health, Minister's Advisory Council on Women's Health, British Columbia Ministry of Women's Equality. p 33

[44] Andrews G, Sanderson K, Slade T, et al. (2000). Why does the burden of disease persist? Relating the burden of disease of anxiety and depression to effectiveness of treatment. *Bulletin of the World Health Organization 78 (4).* Geneva, Switzerland: World Health Organization. http://www.who.int/bulletin/pdf/2000/issue4/bu00-0485.pdf p 78

- Provide information to improve the understanding in the health sector and throughout society of the factors that contribute to good mental health and to mental disorders and substance use disorders.
- Improve the dissemination of evidence-based practices information amongst healthcare providers who are involved in health promotion, prevention, and treatment for people with mental disorders or substance use disorders.
- Make available high quality information and support to those affected by mental disorders and substance use disorders to promote prevention and increase active participation in addressing and managing the illness.
- Provide information to support the implementation of chronic disease management programs to improve outcomes for people with mental disorders and substance use disorders.

9. Support Self-Management Approach including Improving Personal Health Practices, Coping Skills, and Social Support Networks

Personal health practices are key in preventing diseases and promoting self-care. Just as important are peoples' coping skills. Effective coping skills enable people to be self-reliant, solve problems and make choices that enhance health. Social support networks and family education can make important contributions to the development of coping skills for individuals with mental disorders and substance use disorders, as well as for other members of their families. Positive coping skills and personal health practices are important in promoting mental health and supporting recovery from mental disorders and substance use disorders.

Mental disorders and substance use disorders, particularly if untreated, often result in or lead to serious impairments in social functioning. Establishing and maintaining interpersonal relationships becomes very difficult. People are unable to function in such important roles as friend, student, parent, or worker. Self-care skills deteriorate. There is poor participation and little enjoyment in leisure and recreational activities. People become isolated. Ties with family and friends and other personal relationships become strained or severed so that people lack social supports.

However, a considerable body of research demonstrates that these consequences of mental disorders and substance use disorders can be minimized or reversed, when individuals and their families are aided in learning appropriate health practices and coping skills. Improvements in social functioning can influence other areas of functioning, resulting in less disruption from a course of illness and improved quality of life dimensions such as enjoying interpersonal relationships and meeting social expectations.

Mental health and addiction systems of care are shifting from treating clients as passive recipients of treatment, to individuals who are actively involved in the management of their illnesses. A variety of interventions have been developed and include providing education about mental disorders and substance use disorders and their treatment, teaching clients how to recognize and respond to early warning signs of relapse, and

teaching coping strategies for dealing with stress and persistent symptoms. In addition, successfully challenging and modifying dysfunctional beliefs (cognitive restructuring) may decrease negative emotions and lead to more adaptive perceptions and beliefs about the world. These interventions have been used successfully with clients who had persistent psychotic symptoms and in the treatment of anxiety or affective disorders and substance use disorders.

Early recognition of symptoms, respectful provision of the most effective treatments, appropriate support and follow-up and timely access to accurate information all improve the likelihood that the individual will experience minimal secondary disability and associated handicaps and will achieve a higher quality of life in the long-term.

Depression and anxiety in particular have been identified as health conditions that can be addressed through chronic disease management strategies. The chronic disease management model is an evidence-based approach to improving outcomes for chronic health conditions. A key component is supporting self-management skills amongst individuals with various chronic illnesses, including mental disorders and substance use disorders. Jurisdictions that have followed the model have shown significant performance and outcome improvements with respect to depression and other chronic health conditions.

Additional research suggests that other mental disorders in addition to depression and anxiety, such as bipolar illness, psychotic disorders, substance use disorders, schizophrenia, and conditions more specific to women such as eating disorders, or post-partum mental disorders, will benefit from an initiative to support self-management skills. Qualitative research shows that people with various serious mental disorders, including those with co-morbid conditions, highly value, but generally lack access to timely and useful information about how to successfully manage their illnesses. Quantitative evidence exists, for example, from the early psychosis literature, and from the family psycho-education literature, that providing illness-related information and problem-solving skills leads to lower health system utilization, greater quality of life, and in general, accelerates the recovery process for people with serious mental disorders. The literature on mental disorders self-management stresses the importance of improving the individual's "sense of mastery" over his or her illness - an emphasis that parallels the chronic illness self-management literature's focus on the importance of creating "self-efficacy", or helping an individual's perceived and actual ability to master the skills and behaviours needed to reach a desired health outcome.

Illness self-management is a process that starts within the relationship between the client and the treating professional (family physician, psychiatrist, health centre staff, community agency staff, etc.) as the client is collaboratively and actively involved in defining the problem, setting goals and devising, carrying out, and revising their care plan. The self-management process also occurs in complementary fashion as clients gain access, by referral, or through their own initiative, to information and support within the self-help sector, and through community organizations.

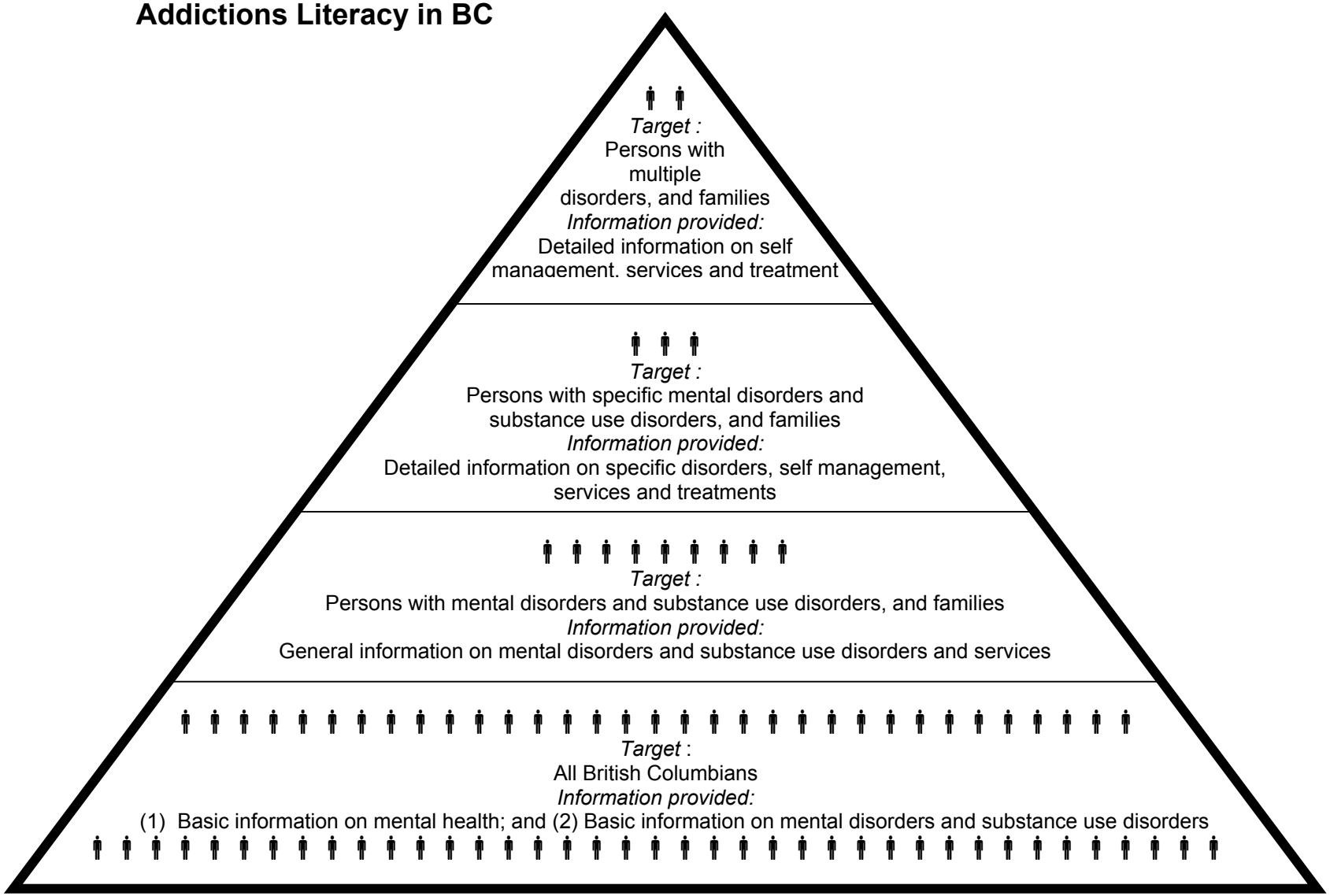
Access to information and assistance to support clients in learning self-management, coping skills and other beneficial personal health practices should be facilitated. Opportunities to develop these skills are key to a quality continuum of mental health and addictions services. They aid recovery, build resiliency and help to minimize future relapse and development of new mental disorders and substance use disorders. Local support groups, self-help groups, peer counselling and educational resources should be included in collaborative mental health and addictions service planning. Self-help groups can and often do, provide a crucial kind of assistance, helping people to overcome the isolation and feelings of low self esteem that frequently accompany mental disorders or substance use disorders, as well as an opportunity to develop and test new skills.

In addition, it is becoming increasingly clear that families need education, mentoring and community support. A number of international studies have established strong relationships between attitudes in relatives and increased relapse rates for individuals with mental disorders and substance use disorders, living with them. By changing the emotional atmosphere in the home, the relapse rates were reduced. Resilience of families with individuals who experience mental disorders and substance use disorders can be strengthened through early sharing of information on a wide range of issues related to the illness(es), exploring family reactions and formulating treatment plans together. Families benefit from learning processes of problem solving in order to manage the illness most effectively. Developing skills in family caregivers supports them to resolve the complicated challenges they face. This process can be reinforced by referral to family support organizations.

A related component on the continuum of mental health and addiction services would be local programs and services supporting families to become more resilient and raise children who are increasing resilient. Partnerships with clients and families should assist them in obtaining evidence-based information and support and in learning appropriate and active caring skills. Local partners would include mental health associations and support groups.

In summary, planned and targeted local information programs and provincial information initiatives can improve mental health literacy in individuals and their families resulting in increased use of effective self-management skills, personal health practices, coping skills, and social support networks to reduce extent of disabilities and the level of need for services (see Figure 2).

Figure 2: Population Targets and Information to be developed for increasing Mental Health and Addictions Literacy in BC



E. The Plan Outline

As the work proceeds on developing the information plan and throughout implementation, the plan must be continually tested against the goals, guiding principles, and key considerations to ensure progress is made.

To achieve a workable plan, components will be addressed in a step-by-step approach, with each year building on the previous year's deliverables and adapted to the changing environment in health care.

The plan has four major components (as illustrated in Figure 1):

1. Develop permanent communication infrastructure;
2. Provide information for mental health and addictions professionals;
3. Provide information to people with mental disorders and substance use disorders and their support groups; and
4. Provide information to sectors of the population of BC.

The communication infrastructure will build on current sources of information. The first step has been taken in having the provincial mental health and addiction agencies who have contracts to provide information, come together and begin work on the plans to provide information to persons with a mental disorder, their families and the public. The agencies are working to meet the following goals:

- Inventory of current information materials;
- Establishment of a database to allow tracking of materials on an ongoing basis;
- Development of a website for common information and ready access to web links with relevant materials;
- Establishment of standards for information/educational materials, and
- Communication plan and dissemination of information.

The infrastructure developed will, at some point, be linked to or situated within the health authority governance structure.

Information for professionals has been and will continue to be managed through Mental Health Evaluation and Community Consultation Unit (Mheccu) at University of British Columbia, in partnership with health authorities, other educational institutions, professional bodies, and provincial mental health and addictions agencies. The standards for best practices and the timing of development of specific work will be undertaken by Mheccu in partnership with stakeholders.

Information for people with mental disorders and substance use disorders including work currently being conducted in part, through the MOHS/HP chronic disease management group and other stakeholders includes for this year:

- Developing basic information on mental health, mental disorders and substance use disorders for public, persons with mental disorders and substance use disorders, and their families

- Developing self-management materials for specific disorders for persons with a mental disorder and substance use disorders and their families. For 2003/2004 the priority is for anxiety disorders and depressive disorders.

The levels of information and the breadth of the target audience are illustrated in Figure 2: Population targets and information to be developed for increasing Mental Health and Addictions literacy in BC.

The partners in Phase One are:

- Anxiety Disorders Association of BC (ADABC)
- Awareness and Networking Around Disordered Eating (ANAD)
- British Columbia Schizophrenia Society (BCSS)
- Canadian Mental Health Association – BC Division (CMHA)
- Kaiser Foundation (Kaiser)
- Mental Health Evaluation and Community Consultation Unit (Mheccu)
- Mood Disorders Association (MDA)

For additional information on agencies, see Appendix A: Information Summaries on Agencies.

A three-year workplan is under development for 2003 to 2005.

Appendix A: Information on Agencies

Anxiety Disorders Association of British Columbia

The Anxiety Disorders Association of British Columbia (ADABC) is a group of consumers and professionals, who work to increase awareness about anxiety disorders, promote education of the general public/affected persons/ health care providers, and increase access to evidence-based resources and treatments.

Association for Awareness and Networking Around Disordered Eating

The Association for Awareness and Networking around Disordered Eating (ANAD) is a non-profit grass roots service provider that receives funds from the provincial and regional health authorities. ANAD is primarily a volunteer driven organization that has educated, informed, and advocated for services and prevention around disordered eating in the communities of British Columbia since 1985. ANAD's mission is to educate individuals and communities to challenge societal norms and to inspire change to prevent disordered eating.

British Columbia Schizophrenia Society

The British Columbia Schizophrenia Society (BCSS) was founded in 1982 by families and friends of people with schizophrenia. There are currently more than sixteen hundred members and over four thousand supporters.

Through its six Provincial Office staff, seventeen Regional Coordinators, and hundreds of volunteers at thirty-four Branches throughout BC, the Society provides and promotes support to families of people with severe mental illness, public education, advocacy, and research.

Canadian Mental Health Association – British Columbia Division

The Canadian Mental Health Association (CMHA), BC Division is a provincial voluntary organization concerned with promoting the mental health of all British Columbians and changing the way we view and treat mental illness in BC. CMHA-BC Division has been serving BC for 50 years and are part of a network of 21 branches across the province that provide both direct services to people with mental illness and a range of public education activities.

Kaiser Foundation

The Kaiser Foundation (Kaiser) seeks to assist communities in preventing and reducing the harm associated with problem substance use by providing quality information on related issues and services.

Mental Health Evaluation & Community Consultation Unit

The Mental Health Evaluation & Community Consultation Unit (Mheccu) is a program within the University of British Columbia's Faculty of Medicine and the Department of Psychiatry's Division of Mental Health Policy & Services. Mheccu's mission is to improve mental health outcomes for British Columbians and for Canadians by linking research, education and policy making at community, clinical, administrative and broader systems levels. Mheccu integrates interdisciplinary research with professional development initiatives and service delivery in partnership with community stakeholders. This collaborative approach reflects the following views on the dissemination and uptake of research: (a) Research that is directly linked to clinical and policy decision makers is more likely to be well informed, and more likely to be implemented by service providers, consumers, and families; and (b) Community stakeholders (administrators, consumers, professionals, etc.) are enthusiastic consumers of empirical research, provided that the results are truly relevant to their situation, and that the material is available in a manner that is convenient and, ideally, is supported by opportunities for consultation and dialogue.

Mheccu works with the provincial government, health authorities and mental health stakeholders, including consumers, families, community agencies, and mental health professionals toward the development of a more integrated and effective community-based mental health system.

Mood Disorders Association of British Columbia

Mood Disorders Association of British Columbia (MDA) provides support and education for people with a mood disorder, their families and friends. MDA cooperates and partners with professionals, agencies and other mental health organizations to encourage research and to educate and build an understanding community.